RSUD AUTH REQUEST FAX COVER SHEET

(To be faxed to 855-244-9359)

Date: mm/dd/yyyy Program Name: Point of Contact:

Phone#: (###) ### - #### Fax #: (###) ### - #### # Pages Included:

For All Requests:

Requested Level of Care: 3.1 ☐ 3.5 ☐ Requested Start Date: mm/dd/yyyy

PO Referral for Assessment/Treatment? Yes ☐ No ☐

Court Order for Residential? Yes ☐ No ☐

Date of Birth Included? Yes ☐ No ☐

Medi-Cal Number or Social Security Number Included? Yes ☐ No ☐

☐ **Initial Authorization:**

- ✓ Date and Time When Request Was Called In:
  mm/dd/yyyy mm:hh AM or PM
- ✓ Initial Level of Care Assessment
- ✓ Health Questionnaire (if rating higher than a 0 in Dimension 2)

☐ **Continuing Authorization:**

- ✓ Initial Treatment Plan
- ✓ ASAM Level of Care Recommendation Form
- ✓ ASI/YAI (Addiction Severity Index/Youth Assessment Index)
- ✓ Health Questionnaire (if rating higher than a 0 in Dimension 2)
- ✓ Diagnosis Determination Note

☐ **Extension:**

- ✓ Updated Treatment Plan
- ✓ ASAM Level of Care Recommendation Form
- ✓ Diagnosis Determination Note, if diagnosis changed

☐ **Request to Change Level of Care:**

- ✓ Updated Treatment Plan
- ✓ ASAM Level of Care Recommendation Form
- ✓ Diagnosis Determination Note, if diagnosis changed

☐ **Discharge:**

- ✓ Discharge Plan/Summary

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